**Demographic Information**

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| 1. **Location of your hospital - Province/State/Region/Territory** | [insert Province/State/Region/Territory] |
| 1. **How would you best describe your hospital?**   *e.g. Tertiary referral hospital* | [insert description] |
| 1. **How would you best describe the location of your hospital?**   *e.g. Metropolitan, remote rural* | [insert description] |
| 1. **How many inpatient beds do you have in your facility?** | [insert number of beds] |
| 1. **Does your facility have a dedicated Acute Pain Service?** | Yes / No |
| 1. **Does your facility have a dedicated clinical pharmacy service in Emergency and Surgical settings?** | Yes / No |

| **Construct 1 – Governance** | **Category 1**  ***Considered***, but not implemented – indicate *which* areas have been considered | **Category 2**  ***Partially implemented*** – indicate which areas/disciplines | **Category 3**  ***Fully implemented*** in some areas or disciplines – indicate which areas/disciplines | **Category 4**  Fully implemented across the facility |
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| * 1. **Does your hospital have a Pain Management, Analgesia or Opioid Stewardship Steering Committee? If yes, does it have multidisciplinary representation from Key Stakeholders and reporting mechanisms to hospital governance committees?**   *Aim of this committee will be to inform, coordinate and action tasks and projects which support comprehensive Stewardship, supported by local data.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does your hospital have mechanisms to identify if balance measures, which are in place to ensure the quality of pain management, are not compromised by changes to opioid prescribing?**   *Key data may include (but is not limited to) rates and qualities of opioid-related incident reports, clinical coding incidents relating to opioids (Y45.0, and others\*\*(?T402 or X42)), results from patient surveys.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does your hospital have policies in place which outline the safe and accountable use (closed loop) of Schedule 8 (controlled drugs) and relevant Schedule 4 medicines by hospital staff?**   *This includes policies and practices around storage (including strategies to avoid selection error), order, transfer, administration (including comprehensive independent second checks) and disposal of controlled drugs within the hospital, management and return of patient’s own controlled drugs, and strategies to identify and address diversion.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does your hospital provide a centralised directory of Opioid Stewardship governance, resources, materials, education and contacts?**   *e.g. local intranet page.*   * [insert notes as required] |  |  |  |  |
| **Construct 1 –** *Special considerations or comments relevant to local context*   * [insert notes as required] | | | | |

| **Construct 2 – Pain Management** | **Category 1**  ***Considered***, but not implemented – indicate *which* areas have been considered | **Category 2**  ***Partially implemented*** – indicate which areas/disciplines | **Category 3**  ***Fully implemented*** in some areas or disciplines – indicate which areas/disciplines | **Category 4**  Fully implemented across the facility |
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| * 1. **Does your hospital provide access to staff from multiple disciplines who specialise in pain management and have capacity to provide a consultative service?**   *This may include an Acute/ Persistent Pain Services and/or addiction services with Medical, Nursing, Pharmacy and other Allied Health staff who can support the management of individual patients or provide an expert resource for other clinicians.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does your hospital have prescribing guidelines for analgesia with an emphasis on non-opioid and non-pharmacological pain management strategies and guidance on maximum doses of high-risk medications such as opioids?**   *This could include locally approved, area-specific pain management guidelines, agreement to the use of Therapeutic Guidelines, additional structure around referral criteria (‘Traffic Light’ System as often used for Antimicrobial Prescribing), analgesia de-escalation guidelines, discharge prescribing guidelines.*  *\*While most opioid medications will not necessarily have a ‘maximum’ licenced dose, it should be agreed within the hospital the dose at which senior or specialist review or approval is required.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does your hospital have processes and guidelines in place to identify, refer and manage the pain of patients who are opioid tolerant and present with a pain complaint or for surgery (including patients on opioid replacement therapy)?**   *This may include referral pathways in pre-admission clinics for patients on >50mg oral morphine equivalents per day. Contacting Prescription Monitoring Services if appropriate.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does your hospital have risk-assessment processes and management strategies for prescribing opioids for pain management to opioid-naïve patients?**   *e.g. use of the Opioid Risk Tool, screening for Obstructive Sleep Apnoea, appropriateness guidelines or staged-supply arrangements. The use of risk assessments should be regularly monitored for compliance.*   * [insert notes as required] |  |  |  |  |
| **Construct 2 –** *Special considerations or comments relevant to local context*   * [insert notes as required] | | | | |

| **Construct 3 – Staff Development** | **Category 1**  ***Considered***, but not implemented – indicate *which* areas have been considered | **Category 2**  ***Partially implemented*** – indicate which areas/disciplines | **Category 3**  ***Fully implemented*** in some areas or disciplines – indicate which areas/disciplines | **Category 4**  Fully implemented across the facility |
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| * 1. **Does your hospital provide access to pain management and opioid safety education modules for medical, nursing and pharmacy staff?** * [insert notes as required] |  |  |  |  |
| * 1. **Does the education on pain management, including the utilisation of opioids, include clear and consistent key messages and is it responsive to the type and location of clinical incidents which have been reported relating to pain management or opioid use?**   *Key messages would ideally include information about the biopsychosocial model of pain, pain assessment strategies (particularly in vulnerable groups like children, the cognitively impaired), strategies for communicating about pain, the role of different analgesics, and appropriate monitoring.*  *Types of education may include in-person in-service presentations, recorded presentations available online or by device, or newsletter and fact sheet-style publications.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does your hospital provide access to interactive pain-related education and resources open to all clinical staff?**   *This may include access to appropriate resources produced by external organisations, such as by the ANZCA Faculty of Pain Management, National Prescribing Service.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does your hospital provide opportunities, or support staff to seek opportunities, to upskill in pain management through formal training, in-house credentialing or clinical placements?**   *This may include fiscal support to undertake qualifications in Pain Management, development of pain management and opioid safety or prescribing credentialing locally, and opportunities for clinicians to round with pain services in or external to the hospital.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does the hospital provide accessible training regarding the use and monitoring of pain management-related devices, such as pumps used for patient-controlled analgesia, epidurals and analgesia infusions?** * [insert notes as required] |  |  |  |  |
| * 1. **Does the hospital schedule a regular Grand Rounds presentation which focuses on a pain management or Opioid Stewardship topic?**   *e.g. a presentation could be included 2-4 times a year with the topic and presenter organised by the Analgesia Steering Committee in response to data, projects in progress and perceived need.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does the hospital ensure education opportunities are developed and delivered by subject matter experts and key stakeholders?**   *Subject matter experts may include clinicians who specialise in pain management or addiction medicine, those with expertise in medication safety, or consumers and consumer advisory representatives. It is important that education is delivered by those who are best placed to speak on a given topic.*   * [insert notes as required] |  |  |  |  |
| **Construct 3 –** *Special considerations or comments relevant to local context*   * [insert notes as required] | | | | |

| **Construct 4 – Patient Care and Consumer Engagement** | **Category 1**  ***Considered***, but not implemented – indicate *which* areas have been considered | **Category 2**  ***Partially implemented*** – indicate which areas/disciplines | **Category 3**  ***Fully implemented*** in some areas or disciplines – indicate which areas/disciplines | **Category 4**  Fully implemented across the facility |
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| * 1. **Does the hospital ensure patients have access to non-pharmacological pain management strategies while in hospital?**   *This may include use of heat, ice, rest, physiotherapy and psychology.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does the hospital provide patient information on analgesia and the safe use of opioid medications which addresses key criteria, that has been developed in partnership with patients?**   *This may include counselling leaflets to provide when opioid medications are being supplied at hospital discharge, reducing dose schedules for opioid medications on discharge, ‘Pain Action Plans’, area-specific information such as for Maternity patients.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does the hospital provide follow-up and clinical support (while inpatients or after discharge) to patients who are identified as being at higher risk of long-term opioid use, adverse events, or who may be able to de-escalate opioid doses following admission?**   *This may include an outpatient clinic or phone review service by pharmacists, nurses or medical staff to monitor for correct and safe use of medications, monitor side effects, and utilises motivational interviewing techniques while liaising with treating team or General Practitioner as needed*   * [insert notes as required] |  |  |  |  |
| * 1. **Does the hospital have policies in place to identify patients who have presented with an opioid overdose and (if appropriate) to refer to drug and alcohol services (while inpatient or at discharge) and (if appropriate) provide them with take-home naloxone at discharge?** * [insert notes as required] |  |  |  |  |
| * 1. **Does the hospital pharmacy promote itself as a place to return any unused or expired analgesic medications or promote the nearest pharmacy which will accept returns?**   *This may include promotion in patient counselling materials, on pharmacy signage, or in local publications such as newspapers, websites or social media accounts.*   * [insert notes as required] |  |  |  |  |
| **Construct 4 –** *Special considerations or comments relevant to local context*   * [insert notes as required] | | | | |

| **Construct 5 – Clinical Handover** | **Category 1**  ***Considered***, but not implemented – indicate *which* areas have been considered | **Category 2**  ***Partially implemented*** – indicate which areas/disciplines | **Category 3**  ***Fully implemented*** in some areas or disciplines – indicate which areas/disciplines | **Category 4**  Fully implemented across the facility |
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| * 1. **Does the hospital set expectations for the content and timing of clinical handover (e.g. discharge summaries) to primary care of patients’ pain management and analgesia prescriptions and is adherence with these expectations monitored?**   *Expectations may include that, at a minimum, the indication, drug, dose and duration of analgesic medications are stated in discharge summaries, which must be forwarded to the patient’s GP within 7 days. Provision and timing of this information could be monitored as part of each ward’s audit cycle.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does the hospital set expectations for the content and timing of clinical handover between teams in an inpatient setting and is adherence with these expectations monitored?**   *e.g., if opioids are prescribed by a specialist team (such as an Acute Pain Service) for an inpatient, their plan for ongoing management of the medication should be handed over to the treating team and should be clearly documented on the medication order AND in progress notes.*   * [insert notes as required] |  |  |  |  |
| **Construct 5 –** *Special considerations or comments relevant to local context*   * [insert notes as required] | | | | |

| **Construct 6 – Clinical-Area Specific Quality Improvement** | **Category 1**  ***Considered***, but not implemented – indicate *which* areas have been considered | **Category 2**  ***Partially implemented*** – indicate which areas/disciplines | **Category 3**  ***Fully implemented*** in some areas or disciplines – indicate which areas/disciplines | **Category 4**  Fully implemented across the facility |
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| * 1. **Does the hospital ward/unit have mechanisms to identify, monitor, compile, report and review data regarding quantity and appropriateness of opioid use and indicators of quality of pain management which are relevant to their specialty?**   *e.g. emergency departments may use different opioids in different circumstances to surgical units which will in turn be different to palliative care units. This diversity means that the measures monitored, and ‘appropriateness’ of use in each clinical area should also be different.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does the hospital ward/unit support quality improvement auditing to be driven by clinicians from the relevant clinical area using specific cycles of audit, feedback, education and re-audit to identify baseline practices and priority areas?**   *An example of this methodology is the Opioid Prescribing Toolkit – OPT and this strategy should support change which is meaningful and achievable within the clinical unit.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does the hospital ward/unit provide data from quality improvement cycles to be collated and compared to similar wards/units at other sites to provide a basis for benchmarking and learning to create an ongoing framework for pain management and opioid use?**   *e.g. it is more helpful to compare two orthopaedic units at different hospitals than it is to compare an emergency department and orthopaedic unit at the same hospital. This also supports benchmarking and enables provision of consistent care across the state.*   * [insert notes as required] |  |  |  |  |
| **Construct 6 –** *Special considerations or comments relevant to local context*   * [insert notes as required] | | | | |

| **Construct 7 – Community Engagement** | **Category 1**  ***Considered***, but not implemented – indicate *which* areas have been considered | **Category 2**  ***Partially implemented*** – indicate which areas/disciplines | **Category 3**  ***Fully implemented*** in some areas or disciplines – indicate which areas/disciplines | **Category 4**  Fully implemented across the facility |
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| * 1. **Does the hospital identify and provide opportunities to interact with General Practitioners and other community providers in promoting pain management and opioid stewardship?**   *This may include invitations to relevant Grand Rounds presentations, or organising forums with local community providers to discuss pain management and opioid stewardship, Q & A evenings, seeking feedback regarding discharge handover, engagement through GP Liaison Officers.*   * [insert notes as required] |  |  |  |  |
| * 1. **Does the hospital advocate key health literacy messages around pain management with the wider community?**   *The key health literacy messages could include: the importance of multidisciplinary pain management, opioid safety advice, responsible opioid disposal.*  *Advocacy could include offering regular education sessions aimed at the general population to which local residents can self-refer. or collaborating with local council to advocate for services or programs which may serve the needs of the local community (e.g. exercise, stretching, or mindfulness programs).*   * [insert notes as required] |  |  |  |  |
| **Construct 7 –** *Special considerations or comments relevant to local context*   * [insert notes as required] | | | | |

**Explanation notes**

Key Stakeholders

* Individuals with organisational knowledge of pain management and opioid stewardship e.g. Director of Pharmacy, Medication Safety Officer, Lead for Acute Pain